BOARD OF COMMUNITY HEALTH
March 10, 2005

The Board of Community Health held its regularly scheduled meeting in the Floyd Room, 20th Floor, West Tower, Twin Towers Building, 200 Piedmont Avenue, Atlanta, Georgia. Board members attending were Jeff Anderson, Chairman; Chris Stroud, M.D., Secretary; Inman English, M.D.; Kip Plowman; Mary Covington; Ross Mason and Kim Gay. Commissioner Tim Burgess was also present. (A List of Attendees and Agenda are attached hereto and made official parts of these Minutes as Attachments # 1 and # 2).

Mr. Anderson called the meeting to order at 1:10 p.m. He recognized and welcomed new board members Kim Gay and Ross Mason. Mr. Anderson appointed Ms. Gay to the Care Management Committee and Mr. Mason to the Audit Committee.

The Minutes of the February 10 meeting were UNANIMOUSLY APPROVED AND ADOPTED.

Mr. Anderson called for public comment. Ms. Cam Grayson of the Medical Association of Georgia made public comment.

Mr. Anderson asked Commissioner Burgess to make his report. Commissioner Burgess reported on the following procurements: 1. Pharmacy Benefit Manager (PBM) – the Department currently has had under contract for several years a Pharmacy Benefit Manager, Express Scripts Inc. The Centers for Medicare and Medicaid Services (CMS) granted the Department last year a short extension, but the Department needed to move forward aggressively with a reprocurement based on CMS' requirements and timelines. The RFP is finished and is being review by CMS now. The current schedule is to issue the PBM procurement toward the end of March for Medicaid, State Health Benefit Plan and Board of Regents Health Plan in hopes of having the new vendor in place by January 1, 2006; 2. Enrollment Broker – the Department is working on and hopes to have in place by early April procurement for an enrollment broker whose responsibility would be to enroll eligible Medicaid members in the successful care management organizations across the state. Commissioner Burgess said the timeline is very tight because DCH needs that procurement completed, contracted and a successful vendor in place by late summer so they can put their system in place and be ready to enroll the first new members in our care management regions beginning next October and November; 3. SHBP Network - the current network has been operated and managed by First Medical Network for several years. Discussions with DCH's consultants last summer and fall suggest that it is not only timely to rebid that PPO Network but there may be opportunities for the Department to save money and create a better arrangement for SHBP with a reprocured PPO network. The Department is working with those consultants now to write the RFP and issue in April. That network would be implemented in January 1, 2006 when the new SHBP plan year begins. Lastly, Commissioner Burgess talked about the SHBP dependent eligibility audit currently being conducted. One of the myriad of proposals made last fall to address the shortfall in the SHBP was to perform a complete, 100% dependent audit. The Department's initial estimate was to save $10 million in future costs.

Mr. Anderson called on Carie Summers, Chief Financial Officer, to begin discussion on the Emergency Ambulance Services (EAS) Public Notice. The public notice was presented to the Board at its February 10 meeting. The Department is proposing to make a change in the reimbursement methodology for emergency ambulance providers effective April 1. Dr. Stroud MADE THE MOTION to APPROVE the Emergency Ambulance Services Public Notice. Mr. Plowman SECONDED THE MOTION. Mr. Anderson called for votes; votes were taken. The MOTION was UNANIMOUSLY APPROVED. (The Emergency Services Public Notice is attached hereto and made an official part of these Minutes as Attachment # 3.)

Mr. Anderson asked Mr. Plowman to update the Board on the Audit Committee. Mr. Plowman highlighted several items. The June 30, 2003 audit has been completed. As expected, the auditors disclaimed an opinion on the governmental funds due to the ACS transition and related issues. The Department is working on the 2004 audit; it is scheduled to be completed in the next few months and is expected to be much improved. A project management team has been installed and has been a big help to the Department in moving forward and strategically focusing on systems problems and fixes. Ms. Summers added that the process is well managed and there is oversight by an Executive Audit Committee composed of Commissioner Burgess; Mr. Anderson; Tommy Hills, State Chief Financial Officer; Lynn Vellinga, State Accounting Officer; Russell Hinton, State Auditor, and Harvey Braswell, President, State Healthcare Solutions, ACS, who meet every Friday. The FY 04 Financial Audit Work Plan called for reprocessing claims adjudicated in FY 04. The reprocessing had to be stopped because of systems defects. Mr. Anderson stated that ACS could not reprocess claims in a reasonable time and an estimation methodology will be used that appears to better and will suffice for the Department to get a true and accurate picture of what DCH's finances look like particularly as it relates to Medicaid billings. Lastly, Mr. Plowman talked about the Audit Committee charter. The Audit Committee is reviewing the redlined copy of the charter, extending its review one more month and in April will bring a final version to the board for consideration.

Ms. Summers began discussion on the FY 05 and FY 06 budgets. She stated that the FY 05 Amended Budget has gone through the entire legislative process and is awaiting the Governor's signature. Ms. Summers briefly described the adjustments, additions, transfers, reductions and redirection in each budget. After entertaining questions and comments from the board, Ms. Summers concluded the update. (Copies of the FY 2005 Amended Appropriations House Bill #84 Highlights, SFY 2005 Comparative Summary of HB 84, and SFY 2006 Comparative Summary of HB 85 are attached hereto and made official parts of these Minutes as Attachments # 4, 5 and 6.)

Ms. Summers began discussion on the Indigent Care Trust Fund (ICTF) Distributions. She stated that the Department had distributed about 60-65% of Disproportionate Share Hospital (DSH) funds and payments to qualified and participating hospitals in January. The remaining amount of money is being held pending the completion of additional onsite reviews by our agency using the Department of Audits to ensure that the data that was used to make the DSH calculations are accurate and previous reviews of this information were done consistently and with the same policy directives in mind. There are almost 100 hospitals participating in the DSH program. Twenty-eight hospitals had been previously reviewed and now 61 additional hospitals will be reviewed. The selection for the hospitals that will be subject to these on-site audits are any hospital that has had a 25% change in their FY 2005 DSH allocation when compared to FY 04, all of the safety net hospitals and any hospital newly eligible for DSH in FY 05. The onsite reviews are expected to be completed in late May and the Department will factor changes into calculations that will be used to determine how the rest of the money will be distributed at the end of June.

Ms. Summers added that the Department received an e-mail from CMS in February regarding the way DCH finances the DSH and Upper Payment Limit (UPL) programs. She says in summary, CMS said the states will no longer be allowed to overmatch the IGTs that are submitted to finance the programs. In addition, CMS was very clear that payments made to hospitals for DSH as well as UPL must be retained by the facility.

Ms. Summers moved on to the Recoupment Efforts update. She reminded the board that the department had made prospective payments to providers at the beginning of the conversion from EDS to ACS from April 2003 to April 2004. The prospective payments were interim payments to providers to ensure cash flow. At the end of FY 04, the Department had about $209 million outstanding in prospective payment balances and collected them primarily through current claims payments to satisfy that balance until the balance is zero. Since July 2004, DCH has recouped and recovered $123 million of that $209 million. Ms. Summers said the recoupment strategy will be divided into two provider types, mental retardation services and all other providers, with different strategies for each type. The recoupment strategy for mental retardation services is: Phase 1 strategy recovers 100% of current claims payment amounts for claims with dates of service prior to April 16, 2004. Phase II strategy recovers a lesser amount of the claims payment for those claims with dates of service after April 16, 2004; through December 2004, 20% of claims payments amounts were recovered and applied to outstanding A/R balances; during January 2005, 30%; during February 2005, 40%, and beginning March, 50%. For all other providers, the recoupment strategy has been at 50% for all claims. That balance is being reduced quickly and would be down $25 million by the end of the year. Most of what is left is from providers who are not claiming. The next steps are during March 2005, a letter will be sent to all non-680/681 providers with no or insufficient claims activity to pay off the outstanding balance by the fiscal year end demanding that payment be made for the outstanding balance within 45 days of receipt of the letter; balances not paid in 45 days will be turned over to a collection agency for attempt to recover outstanding amounts due; at the fiscal year end, any remaining balances due will be turned over to Program Integrity for their review of uncollectibility; for those balances deemed uncollectible, DCH will obtain documentation of uncollectibility to recover the federal share from CMS. Ms. Summers concluded her update after answering questions from the Board (Copies of Status Report of Advanced Payment Recoupments and Prospective Payment Recoupment Strategies are attached hereto and made official parts of these Minutes as Attachments # 7 and 8.)

Mr. Anderson called on Laura Jones, Legislative and External Affairs Director, to give the legislative update. She reported that Senate Bill 140, PeachCare and Medicaid Managed Care Changes, passed out of the Senate Health and Human Services Committee. A floor amendment stripped out the provision to allow the Board of Community of Health to set the income thresholds and set premiums for children under six years of age in the PeachCare for Kids program. The bill has been assigned to the House Insurance Committee. House Bill 392, Quality Assessment Fee for CMO Participants, passed the House on March 3 and has been assigned to the Senate Health and Human Services Committee. House Bill 524, State Health Benefit Plan Legislation, was favorably reported out of Committee on March 9. House Bill 390, State Commission on the Efficacy of the Certificate of Need Program, has undergone two substitutes in Committee.

Mr. Anderson asked Dr. Stroud to give an update on the Care Management Committee meeting. He stated that Kathy Driggers, Chief, Managed Care and Quality, gave the Committee an update on the RFP process for the Medicaid Managed Care proposal. The Department received about 1,000 questions from organizations preparing to bid for the CMO for the regions, all of which have been answered and posted on the website. A bidders conference was held on February 28, with about 50 people in attendance. The Department is now working on a series of amendments and changes to tweak the RFP document to clarify a few questions. The next process is preparing to score all of

the bidders' applications for the contracts to become CMOs in each of the six regions.

Dr. Stroud asked Kathy Driggers to give an overview of the Disease Management RFP. Ms. Driggers mentioned that contrary to public perception that the Department was ignoring or not focusing on the most expensive part of its population which is the Medicaid Aged, Blind and Disabled (ABD), there are many more complex factors included in their care, and it will take a sensitive and longer-term approach to get a very global approach to their care. However, the Department does have a long-term strategy for this population. She stated that the Department strongly believes in disease management and has incorporated it as part of the CMO requirements. DCH has about 1.4 million covered lives in Medicaid; about 400,000 are in the ABD population and 1 million will go into the CMOs. Many of the members in ABD are already under some type of case or care management so the Department is excluding those folks who have Medicare or another type of insurance as a primary payor; members who are institutionalized or in a hospice; those in targeted case management in home and community based waiver programs; enrolled in SOURCE; enrolled in Georgia Cares; and anyone with short-term eligibility categories. That leaves about 100,000 lives and the Department will focus on those.

What is different about the methodology or focus that the Department is taking is that typically a universe of lives is identified from claims data--those people who are already diagnosed with certain conditions. The five common chronic conditions are congestive heart failure, chronic obstructive pulmonary disease, diabetes, asthma and coronary artery disease. The Department will add two other diseases, hemophilia and schizophrenia. In that 100,000 that will be targeted, the Department will move toward a newer concept called "bend the trend." There are members who do not have those conditions but they are very much at–risk for developing them or on the verge. The Department wants the vendors to contact the entire population and work on bending that trend—reaching them before they are over the edge to slow the progression of their conditions.

The Department will accomplish this by means of a State Plan Amendment, and the Department is building on the basis of Primary Care Case Management (PCCM) already in place called the Georgia Better Health Care Program. Many of the folks who are in GBHC will be moved to CMOs. The Department is building disease management as an enhanced PCCM program. DCH thinks it is particularly important to link the primary care oversight with disease management interventions and bring them together. The PCCM will be a voluntary program that is somewhat different from the CMO program and members may opt out at any time. In addition, the Department will make the PCCM program voluntary for certain members who want to participate, particularly the SSI members under age 19.

Ms. Driggers said disease management will be accomplished by regionalizing the state into two regions; an Atlanta/North Region (53 counties) and Central/South (106 counties). The contract will be performance based. The vendors will be contractually accountable for outcomes, both cost savings and health status improvements. The Department is looking for vendors to bid a 4% minimum net savings for the Department and the guarantee is proportionate to the net savings. Part of that will be based on cost savings and part on health status improvements. Mercer, the Department's actuaries, is establishing a financial baseline for this population and will trend it going forward. Ms. Driggers

gave an overview of the timeline; release of RFP on March 2; the offeror's conference is scheduled for March 22; proposals are due April 13; contract awards are expected on May 10; the implementation period will run from May 16-August 12; the program will go live on August 15; and the performance period begins on September 1, 2005. Ms. Driggers recognized Elizabeth Brady of the Department for her work on the Disease Management RFP. Ms. Driggers concluded her report after entertaining questions from the Board.

There being no further business to be brought before the Board at the meeting Mr. Anderson adjourned the meeting at 2:55 p.m.

THESE MINUTES ARE HEREBY APPROVED AND ADOPTED THIS

THE _____ DAY OF _____, 2005.

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MR. JEFF ANDERSON
Chairman

ATTEST TO:

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CHRISTOPHER BYRON STROUD, M.D.
Secretary

Official Attachments: #1 - List of Attendees
#2 – March 10 Agenda
#3 – Emergency Ambulance Services Public Notice
#4 - FY 2005 Amended Appropriations HB 84 Highlights
#5 – SFY 2005 Comparative Summary of HB 84
#6 – SFY 2006 Comparative Summary of HB 85
#7 – Status Report of Advance Payment Recoupments
#8 – Prospective Payment Recoupment Strategies